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ABSTRACT

A meeting involving the Minister of Health and the Minister of Education of Portugal, the World Health Organization Regional Office for Europe, the World Federation for Medical Education, the Association for Medical Education in Europe, and the Association of Medical Deans in Europe is reported. The meeting was attended by ministers and delegations from 25 countries. Its aim was to foster a common understanding of the coordinated action needed to improve medical education by reviewing the current situation in members states of the European Community for use of the "health-for-all" policy and strategy to reorient health care delivery and health personnel development, and to advise on how ministries of health and of education can collaborate. Steps taken by each of the organizations represented are described, highlights of statements by ministers and delegations are summarized, the results of four working groups are reported, and conclusions and recommendations are outlined. The text of the resulting Lisbon Initiative is presented. A summary of "The Reform of Medical Education" in Europe and a list of participants are appended. (MSE)

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TARGET 36

Planning, education and use of health personnel for health for all

Before 1990, in all Member States, the planning, training and use of health personnel should be in accordance with health for all policies, with emphasis on the primary health care approach.

Index:

EDUCATION, MEDICAL
HEALTH POLICY
INTERNATIONAL COOPERATION
HEALTH FOR ALL
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Introduction

The Ministerial Consultation was convened by the Minister of Health and the Minister of Education of Portugal, the WHO Regional Office for Europe, the World Federation for Medical Education (WFME), the Association for Medical Education in Europe (AMEE) (1) and the Association of Medical Deans in Europe (AMDE). It was co-sponsored by the United Nations Educational, Scientific and Cultural Organization (UNESCO), and the Calouste Gulbenkian Foundation provided financial support.

Dr Leonor Beleza, Minister of Health of Portugal, was elected Chairperson and Professor Jana Synkova, Minister of Education of the Czech Socialist Republic, and Professor I. Dogramaci, President, Council of Higher Education of Turkey, were elected joint Vice-Chairpersons. Professor M. Parry, General Secretary for the Association for the Study of Medical Education, United Kingdom, was appointed Rapporteur. The Consultation was attended by ministers and delegations from 25 countries. WHO, UNESCO, WFME, AMDE and AMEE were all represented, and 33 educational advisers from 17 countries also took part.

In the context of the reorientation of Member States' health policies to health for all (HFA) strategies (2), the aim of the Ministerial Consultation was to foster a common understanding of the coordinated action needed to improve medical education. The idea was to review the current situation in European Member States with regard to using the HFA policy and strategy to reorient health care delivery and health personnel development, and to advise on how ministries of health and of education could best collaborate in connection with the latter. The participants were asked to review the report of the World Conference on Medical Education, and to consider strengthening the links between ministries of health and of education, WHO, UNESCO, WFME, AMEE, AMDE and other nongovernmental organizations with responsibility for the development of health manpower. Before the Consultation, the participants had received a working paper entitled "The reform of medical education". An executive summary of that paper appears in Annex 1.

Foundations for a new health policy for Europe - the HFA policy - were laid by the WHO Regional Committee for Europe in 1980 (3). This led to 38 specific health targets being agreed in 1984 by the 32 Member States. One of the these (target 36) deals with the need for changes in medical education so as to produce physicians capable of responding to the HFA challenge. After detailed analyses of underlying factors in the social, cultural, economic and physical environment in each country, Member States gave their complete agreement and support to a series of changes that would improve the health of the people of Europe and make better use of resources. Most of the countries are now well advanced in preparing their national health policies.

For a long time, the Regional Office for Europe has been promoting the introduction of new approaches to the development of health personnel in general and medical education in particular. For instance, it has proposed strategies for strengthening primary health care in undergraduate education, adapting medical training to new health needs and policies, and developing systems of continuing and multiprofessional education.

One very important contribution to educational policies relating to the European HFA strategy and targets was the discussion on health manpower development at the thirty-seventh session of the Regional Committee for Europe

in Bruges (1987) (4), where a reassessment of the objectives of medical education and teaching methods was called for, with emphasis on the knowledge and skills of doctors, public health managers and nurses. The Regional Committee accordingly gave the Regional Office a mandate to prepare a strategy document for health manpower development in support of HFA. This document, based on the European HFA strategy and targets, was to identify the educational changes needed in the training of health personnel.

Despite the value of clinical work, medical care is only one of many factors that determine the health of a population. Health promotion policies, a healthy physical environment and appropriate health services are crucial to health. Despite growing expenditure on health care systems, the general level of health is not improving, and certain population segments are far from receiving an appropriate and acceptable level of care. Regional HFA strategies have led many developed countries to look beyond the therapeutic aspects of medical services and to examine four main areas of concern. These are lifestyles and health, risk factors affecting health and the environment, reorientation of the health care system itself, and the political, managerial, technological, manpower, research and other measures necessary to bring about the changes desired. Most important are the health personnel, who are responsible for transforming old policies and programmes into new ones; hence reorientation of the planning, education and training of doctors and other health personnel is at the heart of the matter.

AMDE and AMEE, although not initially working within the context of the Regional Committee's policy review, took an invaluable step by devoting their annual conferences to a critical review of medical education, with particular attention given to contemporary approaches to health and methods of care. The discussions at the AMDE/AMEE conferences were stimulated by an active programme arranged by WFME, including regional conferences based on reports from authoritative nongovernmental bodies in many European countries. The European Regional Conference of WFME took place in Dublin in 1987. It gave strong support to the recommendations in the reports, and delegates showed an openness and a willingness to accept that medical education is in need of drastic changes in the direction advocated by the HFA policy. The culmination of WFME's four-year consultative programme was the World Conference held in August 1988 in Edinburgh, which led to a Declaration setting out broad aims for reforming and reorienting medical education, and a report recommending an international collaborative programme with detailed recommendations for changes to be introduced at institutional, national, regional and world levels (5).

These recommendations and the important initiatives taken by the WHO Regional Office for Europe were discussed at AMDE and AMEE conferences in Istanbul in 1988, and there was widespread agreement about existing educational deficiencies. These include a bias towards specialist practice, insufficient use of district hospitals and community-based experience for teaching purposes, and undue neglect of health promotion, disease prevention and continuity of care. In many countries, doctors are heavily concentrated in cities, rural areas are underserved, and environmental factors are being overlooked. The reform of medical education has been impeded by the rapid growth of specialization, and educational methods are not being examined critically. New approaches to medical education were widely supported at the conferences, including different learning methods, a broadly based curriculum comprising human relations as well as technical skills, continuity of education from the undergraduate to the postgraduate period, and the continuing education of established doctors. It was said that closer collaboration was needed between

medical schools, other teaching bodies and health care authorities so that changing needs and public attitudes to health care were reflected in medical teaching. Improvements were necessary in educational assessment, and clearer funding provision should be made for all stages of medical education.

At the end of their debate, AMDE members adopted a resolution stating that medical education in Europe should now be based on the European HFA policy. AMEE expressed a similar view, and the two associations subsequently set up a joint task force to work with the Regional Office and promote this development throughout Europe.

A similar need for educational reform has led the Association of Schools of Public Health in the European Region (ASPHER) to pursue, in association with the Regional Office, a development programme for education in public health in Europe that is based on the HFA strategy and targets (1987) (6).

Highlights of statements by ministers and delegations

Twenty-four national delegations made statements in the plenary debates, expressing strong support for the reform of medical education as an integral part of meeting their countries' commitment to new health policies based on HFA. They gave particular weight to making much greater use of community-based services (including primary health care) as a teaching resource, as opposed to specialized centres, to broaden students' perception of health care and give them practical experience of working in health care sectors to which, it was hoped, many more would devote their careers. All undergraduates should be trained in general practice, and postgraduate training in primary care should not be limited to future general practitioners, but be added to the training of other specialists to broaden their experience and give them the opportunity of working as a team with the other health care professions. Similarly, better undergraduate and postgraduate education in public health would improve students' understanding of preventive medicine, environmental health and the evaluation of community health and its relationship to health services, and it would provide another practical example of multidisciplinary collaboration in health care.

Delegates also said that the relationship between the practice of different forms of medical work and its consequences for the health of the population should feature prominently in undergraduate medical education and be reflected in teachers' attitudes. Their leadership by example, both in their clinical work and in their teaching style, was an important factor in developing in students a critical approach to health care and its effectiveness, which they should maintain thereafter throughout their years of practice. Teachers should be selected on educational as well as clinical grounds, and should attend teaching courses to enhance their professional status. It should be possible to evaluate the quality of teaching, as well as the content of the curriculum, from students' achievements.

Continuing education as it exists at present was widely regarded as unsatisfactory. Not only did established doctors need to adapt their knowledge and skills regularly to the rapid growth of medical science and technology, but during continuing education their understanding and attitudes with regard to changes in health needs and the care being provided needed to be reappraised. New initiatives should be taken to construct continuing education programmes using appropriate learning methods, to facilitate participation by all doctors, and to develop multidisciplinary and interprofessional learning opportunities.

Concerning national matters, great stress was given to closer collaboration between ministers of health and of education, and the commitment of ministers in Portugal was warmly applauded. Delegates believed that direct contacts between health and university authorities would have a significant influence on any reorientation of education by the faculty of medicine. It would also act as a stimulus to other faculties and departments with teaching and research commitments directly related to health, such as social science, economics, environmental studies, architecture and information technology (7,8). A university's autonomy should be respected, however. It was suggested that a national steering group could be established to generate guidelines, composed of representatives of the health and education ministries, education and health service authorities, and professional bodies; some countries had already established such groups. In Portugal, high authorities in the ministries of education and of health and the universities had decided to set up a review panel including teachers and students as well as medical educationalists.

As well as deciding on educational policies, national health and education authorities should take steps to make manpower planning more effective by collective action. The personnel required to meet predictable health care needs should be estimated to provide a basis for educational planning, including the allocation of resources and criteria for the enrolment of students. Each country would need to develop its own strategy for reorienting all stages of medical education, priorities being selected according to the particular circumstances and the current state of health care provision. International collaboration, including the free exchange of ideas and experience, would be extremely helpful and supportive of many of the changes being sought in every country.

It was confirmed that UNESCO would collaborate with WHO, which is recognized as the leading agency for medical education, and would provide future support through WHO for the reorientation of health manpower training.

Working group reports

The Conference participants divided into four working groups, each of which considered one of the following four issues.

Goals and content of medical education

This group's theme was how the various phases of present medical education could be adapted to meet estimated and predicted overall health needs. The European HFA policy and strategy would provide a basis for reviewing and changing the content of medical education.

The group proposed that certain principles should be followed:

- government departments, consumer groups, individuals and the health professions should join forces to identify the needs for health and health care;

- everyone concerned, especially the health professions and health service authorities, should participate in objective-setting, planning or reorientation of services, and delivery of health care in accordance with HFA-based policies, the aims being to ensure equity, to develop primary health care and good teamwork, to promote health and prevent disease, and to make the best use of available resources;

- every part of the health care system should be evaluated in terms of input, process and outcome to ensure that benefits are brought to each individual efficiently and effectively;

- medical schools should relate education and research to the HFA strategy, evaluate the relevance of existing approaches and curricula, and motivate teachers and educational leaders for any necessary changes.

Medical graduates should have a basic knowledge of health care policies and strategies. They should master communication and management skills and possess a knowledge of epidemiology. They should also possess social awareness, an understanding of behaviour, clinical and the ability to work well as team members in preventive and curative medicine. The same principles should apply to postgraduate and continuing medical education.

To ensure the acquisition of knowledge, skills and the right attitudes to continuing care, health promotion and disease prevention, the medical schools should make these subjects more scientifically valid by promoting interdisciplinary research, and there should be increased emphasis on the behavioural sciences and epidemiology, with opportunities for teaching and learning outside the hospital environment.

The establishment of medical education units closely associated with the decision-making centre (the medical dean's office) should lead to better interdepartmental collaboration and interdisciplinary teamwork. Like other professionals, teachers require continuing education to learn how to teach better and how to help students to learn by participatory, problem-solving methods.

Awareness of the importance of human and social values in medicine should be strengthened by including human rights and ethics in education programmes, and by exposing students to learning situations in which these human and social values are demonstrated.

Educational strategies

The second group was asked to consider how the quality of care might be improved by reorienting medical education and how the methods used in medical schools might be made more appropriate. The report of the World Conference and the Edinburgh Declaration were taken as a starting point.

It was proposed that each country should design its own strategy for educational policies, so there could be no single approach, but key common elements could be defined. Health and education authorities should make a joint declaration on the need to introduce educational reforms in line with official policies. Health authorities should make sure that the professional training being provided, including for the non-medical professions, was adequate and should involve key health care experts as well as medical educationalists. Permanent groups should be set up to monitor recommendations and make sure they were followed; this monitoring was essential, and when detailed studies had been made a permanent group should hol an open debate on the main issues, including training methods and the implementation of reforms in medical schools.

Mechanisms for cooperation and collaboration between educational and health authorities

This group considered the rationale for setting up or strengthening permanent mechanisms for collaboration between ministers of health, ministers of education, medical schools and universities, so that they can together decide on and implement both the qualitative and quantitative aspects of change. The group attached particular significance to the need to enable learning to take place in the correct environment, to overcome the problems caused by restricting students' practical experience to selected hospitals, to develop teaching strategies involving community-based as well as hospital staff, and to learn how to evaluate health care services, with the aim of improving the health of the population and preventing illness as well as treating it.

Although a variety of situations and types of institution control or affect medical education, depending on the country, the group felt that some problems, although they do not affect all parts of Europe, were common enough to deserve collective consideration and that most of them arose because of unsatisfactory cooperation between educational and health institutions. They agreed that correction of this deficiency was the only way for medical education to improve. Better cooperation was not simply a matter of relationships between individual institutions, but firm commitments from political and central sources. Problems originating in a lack of cooperation could be noticed in the deficiencies in manpower policies. Having a manpower policy was an important objective for every country, but although some of the planning and implementation could be done by one sector in isolation from the other, the process as a whole should be undertaken jointly so as to produce a rational, adequate educational system related to health needs and resources. Both national and institutional collaboration between the education and health services ought to be considered.

The number of students should be adjusted to predicted national health care requirements, and admission policies should be based on the resources available for training competent professionals. To design and implement an educational policy relating to HFA, a country needed to adopt a curriculum frame to which institutions could relate, establish a link between undergraduate, graduate and continuing education, and lay down guidelines for the use of health services for education.

National collaboration should also aim at creating:

- information channels that ensure a proper response to new circumstances, so that education is adjusted to social changes (e.g. the social, economic and health implications of AIDS or increased unemployment, which in some countries is leading to mental disorders); and

- feedback on the quality of graduates emerging from education, so as to remedy any deficiencies or discrepancies between education and competence.

As regards the medical schools, the proper settings for education are essential. At the moment, medical education is carried out mainly in highly specialized teaching hospitals, but it should extend to other settings such as general hospitals, primary health care and general practitioner services, so as to train students in the environment in which they will work in future; learning is best achieved by "doing" rather than by "listening". The group felt that the quality and number of teachers were not easy matters to resolve,

opinions being divided. The merit of medical school teachers was judged more by their research and clinical activities than by their teaching capabilities: the assumption that a good researcher or clinician was automatically a good teacher should be challenged. The new European health policy required teachers with untraditional abilities, skills and knowledge. These teachers will have to depend for their work on the health system. Health and educational institutuions should therefore collaborate in their training, in the allocation of time for teaching and in the funding of teachers.

Development and reorientation of the national curriculum to the European HFA policy would require close collaboration and guidelines. The medical schools would retain their autonomy as regards curriculum content and educational strategies. The group's general conclusions were that:

- close, structured collaboration between health and education authorities was the only way for reform in medical education to proceed;

- a manpower policy was necessary, and for its formulation there should be representatives from both sectors; and

- there was an urgent need for an institutionalized joint body, national level and sometimes local, to plan, implement and assess the whole process of medical education.

International collaboration and European plan of action

The fourth group's theme was how national authorities and international organizations (particularly WHO, UNESCO, WFME, AMEE and AMDE) could join forces and succeed in carrying out the reforms required. The group concentrated on conditions for European cooperation and made practical and concrete suggestions. Innovative ideas for change and improvement in medical education in Europe would be stimulated and exchanged through European and international debate. Variations in types of health services and in relationships with the systems of medical education in each country would mean different sets of priorities for introducing the changes required. None the less, overall goals were similar and there was much to be gained by the free exchange of experience and experimental results between countries, medical faculties, scientific and professional organizations, health authorities, care organizers, and so on.

The exchange of knowledge and experience in medical education circles would be particularly helpful in the development of new teaching and learning methods, self-learning techniques, the use of modern data processing methods, medical audit and quality assessment for educational purposes. European cooperation should not be limited to the exchange of ideas and experience, but should also include the exchange of students and teachers. Certain parts of the medical curriculum, preferably in the latter half of basic medical education, could be studied either at home or in another country; periods of elective study could also be included in the curriculum. Primary care was an important field for this type of study, and medical schools should offer opportunities for student and teacher exchange.

Developments often started in a place or institution where especially positive circumstances prevailed and where creative and active people took the lead. Medical schools in various European countries had initiated educational reforms and experiments with good cooperation between departments, applying new principles and methods, introducing new technologies of educational value, appreciating the educational merits of teachers, and setting up units for

educational research and development. This naturally attracted visiting students and teachers. Schools with advanced and well developed systems of education could offer consultation or external evaluation to other schools as a way of accelerating reforms.

The group discussed the development of postgraduate and continuing education, the latter being the most important current problem in medical education, especially for general practitioners. Continuing education should emphasize such matters as the capacity and motivation for independent learning, self-assessment and self-study, practice orientation and service association, the use of new communication technologies, the need for up-to-date, comprehensive reviews of knowledge and skills, and so on. The development of continuing education would require the competence and energy of many interested parties, notably faculties and professional organizations.

In Europe, a number of organizations related to medical education provide opportunities for the exchange of experience and expertise. It is also necessary to create an educational framework for placing educational policies in the context of health and health care services. European associations such as AMEE, AMDE and ASPHER are ready to work for European cooperation in medical education, in full collaboration with WFME, and for the development of education in the direction set by the HFA policy. Similar associations for allied health personnel should also be invited to participate, through intercountry health development networks, in the framework of the European HFA movement.

Conclusions and recommendations

The Ministerial Consultation, responding to the European Regional Committee's report to consider the education of the health professions in the light of the European HFA policy, was in full agreement that medical education should be reoriented to health needs. It was a government's responsibility to make sure that comprehensive health services were provided for the whole population, offering equality of access and equal service for equal needs. Rapid growth in medical knowledge and technological developments has resulted in impressive developments in specialist services, but insufficient attention is paid to primary care, community services, health promotion and disease prevention. Medical education should be responsive to all health problems, and to the need to commit resources and services that lead to improvements in health and the quality of life in a cost-effective way. There was a lack of links between academic and health service sectors and insufficient support for interdisciplinary education.

The curriculum was overburdened and, caught in the trend to specialization, medical schools neglected to prepare doctors for a style of practice that should be devoted as much to health promotion as the treatment of disease. Simply adding to the curriculum was not enough: each aspect of it should be analysed critically and its priorities reordered. Training for primary care services should be given greater stress, together with closer collaboration with other health professions and training in teamwork. Training in community settings would enable students to feel more at home with the health care problems they actually encounter in practice rather than the selected cases found in specialized hospitals. Examinations should be performance-based. Better links should be established between undergraduate and postgraduate education, with particular attention to vocational training in general practice. Self-directed learning should be introduced in undergraduate education, extended to postgraduate training and maintained as a feature of continuing education.

The delegates proposed that all European countries should consider taking action on the principles embodied in the Lisbon Initiative, which reflected their consensus. The Initiative was issued at the end of the Consultation and is reproduced here:

THE LISBON INITIATIVE

Delegations of the ministries of health and education and other authorities in charge of higher education and health of the Member States of the European Region of WHO, meeting in Lisbon in November 1988, expressed their wish for medical education to be reoriented to make it more relevant to health needs.

The Ministerial Consultation recalls that all Member States of the European Region adopted in 1984 a joint health for all policy, and that in 1987 the Regional Committee requested the WHO Regional Office for Europe to consider the implications of this health for all policy for health personnel development, and to report back to it in 1990. The Consultation welcomes the important process started by the World Federation for Medical Education through its Edinburgh Declaration. The Consultation is also encouraged by the support given by UNESCO through WHO to improving medical education in Europe.

In line with this philosophy and based on the statements made by the delegations and discussions in the working groups, the participants in the Ministerial Consultation in Lisbon propose that action should be considered by all European countries on the following principles.

1. A country's medical education policy should reflect a clearly defined health policy stemming from the European health for all strategy.

2. Clear and effective mechanisms should foster close cooperation between the health and education sectors in the establishment of a policy and programmes for health professional education.

3. Educational programmes in individual universities and medical schools should reflect the above-mentioned country policies.

4. Mechanisms and resources should be developed, in cooperation with professional societies, for making continuing education an essential feature of medical education.

5. All phases of medical education should take place in appropriate settings which reflect all aspects of health and health services.

The Ministerial Consultation welcomes the educational innovations undertaken in many countries and institutions. The progress of such innovations should be monitored and assisted by the WHO Regional Office for Europe, UNESCO and associated nongovernmental organizations such as the AMDE, the AMEE and the WFME, as required. The World Conference on Medical Education has proposed an international collaborative programme for reorientation of medical education. Close cooperation should include the exchange of advice and expertise between all countries at both institutional and national levels.

The Ministerial Consultation was most encouraged by the firm decision taken by the Ministers of Education and Health of Portugal to take immediate steps to start the process for ensuring change in line with the Edinburgh Declaration and the European Health for All strategy. The Ministerial Consultation proposes that all other countries should consider following this example.

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Annex 1

EXECUTIVE SUMMARY OF "THE REFORM OF MEDICAL EDUCATION"

In most Member States of the European Region, health care institutions, including tertiary care hospitals, often do not fully respond to public needs and expectations. Continuity of care, health promotion and disease prevention are often neglected. In many countries, there is growing concern about the surplus of doctors, and they are disproportionately concentrated in cities as urban specialists.

Cooperation between medical education and health care providers is not satisfactory, and as a result education does not address all the technical and social issues which are of concern to the population. Curricula lack objectives related to future professional responsibilities, particularly in respect of the community approach to health and disease, and the delivery of promotive, preventive and rehabilitative health care.

Most of the traditional methods of education used in medical schools are inadequate to support the much-needed reorientation of medical education. The introduction of new approaches such as problem-based learning has been limited. Learning how to learn and to continue learning throughout life is not emphasized. Many other areas such as training for teamwork, motivation of students, admission policies, training of teachers and methods of assessment have been unduly neglected up to now.

The critical importance of addressing these issues has been underlined by a series of recent events of major significance for health and medical education.

The first of these events was the approval by the WHO Regional Committee for Europe of a European HFA policy in 1980 and of 38 specific targets for Health for All (HFA) in 1984. The Member States thereby created, in a most decisive way, a joint health policy for the European Region as a whole. Since then, governments have increasingly used the targets for their national policy-making. By now, over half of the Member States have started or even completed the formulation of national health policies and programmes based on the regional policy. Furthermore, the debate on HFA is now spreading beyond central governmental institutions to different administrative levels and professional groups. Such initiatives have taken place in association with schools of public health, "healthy cities", national medical associations, nursing associations, etc.

To be effective, this new approach to health implies a genuine reorientation of the education of health personnel, and particularly medical doctors, at the undergraduate, postgraduate and continuing education levels. In that respect the WHO Regional Office for Europe is collaborating not only with governmental authorities but also with nongovernmental organizations active in this field in Europe, such as the World Federation for Medical Education (WFME), the Association for Medical Education in Europe (AMEE), the Association of Medical Deans in Europe (AMDE), and the European University Network for Health for All (EURUN). At their 1988 annual conference in Istanbul, AMEE and AMDE decided to set up, in cooperation with WHO, a working group on HFA as a basis for medical education.

In 1987 a working paper on "Health personnel development in support of Health for All" was submitted to the thirty-seventh session of the Regional Committee in Bruges. It analysed the implications of the HFA policy for health personnel and put forward several important recommendations aimed at identifying and closing the existing gaps between HFA requirements and health personnel development in the European Region. On this occasion resolution EUR/RC37/R7 was adopted, requesting an extensive dialogue with the appropriate representatives of governments, universities and nongovernmental organizations in order to devise a framework for health personnel development supportive of Health for All.

This framework has to conform to the needs and possibilities of the different Member States in the Region, and the process leading to its production will therefore require consultation with and involvement of all ministries and institutions having responsibilities in the training of medical doctors and other groups of health personnel.

Concommitantly, WFME initiated a four-year process of investigation culminating in the World Conference on Medical Education, held in Edinburgh in August 1988 under the co-sponsorship of WHO, UNICEF, and UNDP. Information for this purpose was first gathered through national reports. Six regional conferences were then held. The conference for Europe took place in Dublin, in September 1987, and those for the other five regions in Brazzaville, Caracas, Amman, New Delhi and Kuala Lumpur.

The Dublin conference adopted 34 recommendations for making medical education, in all its phases - basic education, postgraduate training and continuing education, more congruent with the health care needs of the countries of Europe. These recommendations were derived from the national reports, which had been prepared by almost all of the countries in response to a WFME document, "Six Major Themes", setting out 34 main issues. The European recommendations were then consolidated with those from the other five regions in a discussion document for the World Conference.

The World Conference concluded with the adoption of the Edinburgh Declaration, which cited defects long identified in the training of doctors, and solemnly pledged a commitment to 12 specific improvements.

To a remarkable extent, all the principles of the Edinburgh Declaration are fully in line with the regional HFA strategies. In particular, it calls for cooperation between ministries of health and of education, community health services and other relevant bodies in joint policy development and the planning, implementation and review of programmes. Both it and, more particularly, the conference report specify different actions that must be taken, pointing out that much can be achieved by a reallocation of the resources already available. So many of the conference recommendations have legal, legislative and statutory implications that reform of the training of doctors, and hence improvement of the health of populations, cannot be brought about unless governments are involved at the highest levels.

The Ministerial Consultation is being convened in order to redefine priorities for training doctors, with the involvement of ministries of health and ministries of education.

Ministers of health and of education, with their advisers, will consider the actions that must now be taken, within countries and internationally, to

bring about the improvements in health care and medical education that are urgently required.

An international programme of support for the reorganization of medical education, involving all countries in Europe, will be considered by the Consultation in collaboration with WHO, UNESCO, WFME, AMEE, AMDE and other agencies.

Annex 2

LIST OF PARTICIPANTS

ALBANIA

Dr N. Skuqi
Vice-Minister of Education, Ministry of Education, Tirana

Dr V. Zogu
Dean, Faculty of Medicine, Tirana

AUSTRIA

Dr M. Matzka
Sekretär des Bundesministers für Gesundheit und öffentlicher Dienst, Bundeskanzleramt, Vienna

BELGIUM

Dr J.P. Dercq
Médecin en chef-directeur, Service art de guérir, Ministère de la santé publique et de l'environnement, Cité administrative de l'Etat, Brussels

Dr Y. Messens
Communauté française, Brussels

Professeur L. Tielemans
Médecin-directeur, Hôpital universitaire VUB Jette, Brussels

Mr R. Totté
Directeur général, Administration de l'enseignement supérieur, Ministère de l'éducation nationale, Brussels

Dr A. de Wever
Conseiller, Cabinet du Ministre des affaires sociales, Brussels

BULGARIA

Professor Anna Kaloianova
Head, Department for Postgraduate Education, Medical Academy, Sofia

Professor P. Uzunov
Director of Medical Education, Ministry of Public Health and Social Care, Sofia

CZECHOSLOVAKIA

Professor I. Hatiar
Director, Institute for Postgraduate Education of Physicians and Pharmacists, Bratislava

Professor A. Kohut
Dean, Medical Faculty, Kosice

Professor A. Satanek
Vice-Director, Institute for Postgraduate Education of Physicians and Pharmacists, Prague

Professor O. Sobeslavsky
Director, Institute for Postgraduate Education of Physicians and Pharmacists, Prague

Professor Jana Synkova
Minister of Education, Ministry of Education, Youth and Sport of the Czech Socialist Republic, Prague

FINLAND

Professor Maija Horsmanheimo
Dean, Medical Faculty, Department of Dermatology, University of Kuopio

Dr K. Puro
Secretary-General, Ministry of Social Affairs and Health, Helsinki

FRANCE

Mrs Lilly Weibel
Médecin-inspecteur général, Adjoint au Sous-directeur des professions de santé, Direction générale de la santé, Ministère de la solidarité, de la santé et de la protection sociale, Paris

GERMAN DEMOCRATIC REPUBLIC

Dr J. Grosz
Leiter der Hauptabteilung Aus- und Weiterbildung, Ministerium für Gesundheitswesen der Deutschen Demokratischen Republik, Berlin

Professor J. Schmidt
Rektor der Medizinischen Akademie "Carl-Gustav Carus", Dresden

Professor K. Thielmann
Stellvertreter des Ministers für Hoch- und Fachschulwesen, Ministerium für Hoch- und Fachschulwesen, Berlin

Dr R. Weiner
Bezirkskrankenhaus St. Georg, Leipzig

GREECE

Professor F. Fessas
Dean, School of Health Sciences, Athens University

Ms Marin Kanellopoulou
Director of Health Manpower Development, Ministry of Health, Welfare and Social Security, Athens

Dr A. Sakellaridis
Director, International Relations Division, Ministry of Health, Welfare and Social Security, Athens

HUNGARY

Dr L. Belsö
Head, Department for Personnel and Higher Education, Ministry of Social Affairs and Health of the Hungarian People's Republic, Budapest

Dr Judit Cséhák
Minister of Social Affairs and Health, Ministry of Social Affairs and Health of the Hungarian People's Republic, Budapest

Professor I. Forgacs
Pro-Rector of Education of the Postgraduate Medical School, Director of the Institute for Social Medicine of the Postgraduate Medical School, Budapest

Dr M. Kökény
Deputy Minister for Social Affairs and Health, Ministry of Social Affairs and Health of the Hungarian People's Republic, Budapest

Mrs Katalin Novak
Head, Division for Bilateral Cooperation, Ministry of Social Affairs and Health of the Hungarian People's Republic, Budapest

Dr E. Somogyi
Rector, Semmelweis Medical School, Budapest

IRELAND

Dr R. O'Hanlon
Minister of Health, Custom House, Dublin

Mr J. Hurley
Assistant Secretary, Department of Health, Custom House, Dublin

Mr N. Usher
Assistant Principal Officer, Adviser to the Minister of Health, Custom House, Dublin

ITALY

Dr Francesca Cicogna
Medical Officer, International Relations Office, Ministry of Health, Rome

Professor M. Colombini
Director, International Relations Office, Ministry of Health, Rome

Ms Elena Marinucci
Under-Secretary of State for Health, Ministry of Health, Rome

Dr Licia Sauro
Chief of Secretariat of Under-Secretary of State for Health, Ministry of Health, Rome

Dr G. Zotta
Administrative Officer, Chief of Office for Medical Education, Ministry of Health, Rome

LUXEMBOURG

Dr J. Kohl
Directeur de la santé, Direction de la santé, Luxembourg

MALTA

Professor P. S. Inglott
Pro-Rector, University of Malta, Valletta

NETHERLANDS

Professor G.M. van Etten
Head, Staff Bureau for Policy Development, Ministry of Welfare, Health and Cultural Affairs, Rijswijk

Dr R. Scherpbier
Dutch Association of Medical Association, Department of Surgery, University of Groningen

NORWAY

Professor H. Stalsberg
Professor of Morphology, University of Tromsö

POLAND

Professor G. Janczedwski
Dean, Medical Faculty, Warsaw

Professor Z. Kleinrok
Rector, Medical Academy, Lublin

Professor L. Kryst
Under-Secretary of State, Ministry of Health and Social Welfare, Warsaw

PORTUGAL

Dr Faria de Almeida
Joint Secretary of State, Ministry of Health, Lisbon

Dr Leonor Beleza
Minister of Health, Lisbon

Mr R. Carneiro
Minister of Education, Lisbon

Dr C. Pedro Nunes
Director-General of Higher Education, Ministry of Education, Lisbon

Professor L.N. Ferraz de Oliveira
Rector, Institute of Tropical Medicine, Faculty of Medicine, New University of Lisbon

Professor Esperança Pina
Rector, President of CRUP, New University of Lisbon

SAN MARINO

Dr S. Canducci
Coordinateur, Conseil des personnels de santé, Direction de la santé et de la sécurité sociale, San Marino

Mr R. Ghiotti
Ministre de la santé et de la sécurité sociale, Direction de la santé et de la sécurité sociale, San Marino

SPAIN

Dr J. Artells Herrero
Director-General of Planning and Evaluation, Ministry of Health and Consumer Affairs, Madrid

Dr F. de Asis de Blas
General Director of Higher Education, Ministry of Education and Sciences, Madrid

Dr Carmen Ferrero
Executive Adviser (Education) to the Minister of Health and Consumer Affairs, Ministry of Health and Consumer Affairs, Madrid

Dr L. Plaza
Secretary, National Council of Medical Specialists, Ministry of Health and Consumer Affairs, Madrid

Dr J.L. Rodriguez
Technical Director in the Cabinet of the Minister of Health and Consumer Affairs, Ministry of Health and Consumer Affairs, Madrid

Dr P. Saturno
Deputy Director-General for Health Planning and Education, Ministry of Health and Consumer Affairs, Madrid

Dr F. de la Torriente
Sub-Directorate General of Health Sciences and Relations with Health Institutions, Madrid

Dr J. Garcia Vargas
Minister of Health and Consumer Affairs, Madrid

SWEDEN

Ms Birgitta Bratthall
Head of Section, Ministry of Health and Social Affairs, Stockholm

Mr J. Hultin
Head of Department for Manpower Development, National Board of Health and Welfare, Stockholm

Ms Karin Odencrants
Head of Section, Ministry of Education and Cultural Affairs, Stockholm

SWITZERLAND

Dr R. Salzberg
Mitglied des Vorstandes der Schweizerischen Ärztegesellschaft FMH, Basle

Dr Stephanie Zobrist
Adjointe scientifique, Office fédéral de la santé publique, Berne

TURKEY

Professor I. Dogramaci
President, Council of Higher Education of Turkey, Ankara

Professor D. Taner
Dean, Faculty of Medicine, Hacettepe University, Ankara

UNION OF SOVIET SOCIALIST REPUBLICS

Dr I.N. Denisov
First Deputy Minister of Health, Ministry of Health of the USSR, Moscow

Mr O.V. Maljugin
Assistant Professor, Central Institute of Advanced Medical Studies, Moscow

Professor E.I. Sokolov
Rector, Moscow Medical Stomatological Institute

UNITED KINGDOM

Dr A.J. Isaacs
Senior Principal Medical Officer, Medical Division, Department of Health, London

Ms Jennifer Mixer
Principal, International Relations (Health), Department of Health, London

Dr R.M. Oliver
Deputy Chief Medical Officer, Department of Health, London

RESOURCE PERSONS

Professor Milagros Garcia Barbero
Department of Medical Education, Medical Faculty, University of Alicante, Spain

Professor B. Berkarda
Section of Medical Oncology, Department of Community Medicine, Cerraphasa School of Medicine, Istanbul, Turkey

Dr R. Brearly
UK Representative on Specialist Practice, Consultant Surgeon (retired), Advisory Committee on Medical Training of the European Commission, Liverpool, United Kingdom

Dr J.A. Bury
Directeur, Unité de pédagogie des sciences médicales, Faculté de médecine Université catholique de Louvain, Brussels, Belgium

Dr W.D. Clarke
Director, British Life Insurance for Health Education (BLITHE), BMA House, Tavistock Square, London, United Kingdom

Professor A. Coelho
Director, National Institute of Health Ricardo Jorge, Lisbon, Portugal

Professor P. Cornillot
Président, Université Paris-Nord, Villetaneuse, France

Professor David-Ferreira
Gulbenkian Institute of Sciences, Oeiras, Portugal

Professeur D. Enachescu
Doyen, Chaire de médecine sociale, Institut d'hygiène et de la santé publique, Bucharest, Romania

Professor Lobato Faria
Director, National School of Public Health, Lisbon, Portugal

Professor Wanda Ferreira
Institute of Hygiene and Tropical Medicine, Lisbon, Portugal

Dr V. Ghetti
Director, Fondazione Smith Kline, Milan, Italy

Professor Nuno Grande
Institute of Biomedical Sciences, Faculty of Medicine of Porto, Portugal

Dr O.K. Harlem
Medical Doctor, P.O. Box 34, Snaröya, Norway

Professor I. Hörven
Eye Department, Oslo University, Norway

Professor M. Isokoski
Chairman, Advisory Board, Continuing Education Centre, University of Tampere, Finland

Professor Z. Jaksic
Director, Andrija Stampar School of Public Health, Medical Faculty, Zagreb, Yugoslavia

Professor V. Janousek
Department of Pathological Physiology, Medical Faculty, Charles University, Prague, Czechoslovakia

Professor J.G. Jordanov
Deputy Rector, Medical Academy, Sofia, Bulgaria

Dr H. Karle
President, Nordic Federation for Medical Education, University Hospital, Copenhagen, Denmark

Professor W. Lammers
Department of Pharmacology and Clinical Pharmacology, University of Groningen, Netherlands

Professor Silva Leal
Dean, Faculty of Medicine of Porto, Portugal

Dr G. Lolli
President, International Federation of Medical Students' Associations (IFMSA), L'Aquila, Italy

Dr A.W. Macara
Secretary General, Association of Schools of Public Health in the European Region (ASPHER), Department of Epidemiology and Community Medicine, University of Bristol, United Kingdom

Professor Mario Mendes
Dean, Faculty of Medicine of Coimbra, Portugal

Dr J. Nystrup
Nordic Federation for Medical Education, University Hospital, Copenhagen, Denmark

Professor A. Oriol-Bosch
Institute of Health Studies, Barcelona, Spain

Professor Torres Pereira
Faculty of Medicine, Hospital de Santa Maria, Lisbon, Portugal

Professor Sousa Pinto
Faculty of Medicine of Porto, Portugal

Professor G. Salvatore
Professor of General Pathology, Dean of the Second Medical School, University of Naples, Italy

Professor W. Tysarowski
Director, Department of Education and Health Information Centre, Medical Academy, Warsaw, Poland

Professor A. Wojtczak
Head, Department of International Health, Medical Centre for Postgraduate Education, Warsaw, Poland

Dr A. Wynen
President, European Academy for Continuing Medical Education, Bad Nauheim, Federal Republic of Germany

OBSERVERS

Professor Cordeiro Ferreira
Faculty of Medicine, New University of Lisbon, Portugal

Professor Salles Luis
Faculty of Medicine, New University of Lisbon, Portugal

Professor Machado Macedo
President, Association of Portuguese Medical Doctors, Lisbon, Portugal

Dr Paulo Moreira
Chief of Cabinet of the Joint Secretary of State, Ministry of Health, Lisbon, Portugal

Dr J.M. Paraíso
Chief of Cabinet of the State Secretary for Health Administration, Ministry of Health, Lisbon, Portugal

Professor Costa Previdência
Faculty of Medicine, University of Coimbra, Portugal

Mr H. Ribeiro
President, Federation of Students' Associations (UNL), Faculty of Medicine, New University of Lisbon, Portugal

Dr M. Viegas Tavares
Adviser to the Minister of Education, Ministry of Education, Lisbon, Portugal

Dr F. Vieira
Press Counsellor, Ministry of Health, Lisbon, Portugal

SECRETARIAT

Dr J.E. Asvall
Regional Director, WHO Regional Office for Europe, Copenhagen, Denmark

Dr M.A.R. Dias
Director, Division of Higher Education and Training of Personnel of Education, United Nations Educational, Scientific and Cultural Organization, Paris, France

Professor J.L. Doria
Faculty of Medicine, New University of Lisbon, Portugal

Professor M.N. Ferreira
Dean, Faculty of Medicine, New University of Lisbon, Portugal

Dr M. de Lemos
Chief of Cabinet of the Minister of Health, Ministry of Health, Lisbon, Portugal

Professor A.H.G. Love
President of the Association of Medical Deans in Europe (AMDE), Dean of the Faculty of Medicine, The Queen's University of Belfast, United Kingdom

Dr J.-P. Menu
Regional Officer for Health Manpower Development, WHO Regional Office for Europe, Copenhagen, Denmark

Professor G. O'Neill
Faculty of Medicine, New University of Lisbon, Portugal

Dr M. Parry
General Secretary, Association for the Study of Medical Education, Scottish Council for Postgraduate Medical Education, Edinburgh, United Kingdom

Dr J. Rochon
Director, Programme Management, WHO Regional Office for Europe, Copenhagen, Denmark

Dr C. Rosenfeld
Special Adviser to the Director-General, United Nations Educational, Scientific and Cultural Organization, Paris, France

Professor C.M. Sarmento
Faculty of Medicine, New University of Lisbon, Portugal

Professor G. Ström
President of the Association for Medical Education in Europe (AMEE), Department of Clinical Physiology, University Hospital, Uppsala, Sweden

Professor H. Walton
President of the World Federation for Medical Education (WFME), The Medical School, University of Edinburgh, Teviot Place, Edinburgh, United Kingdom